Authorization for Release of Protected Health Information

Health Insurance Portability and Accountability Act (HIPAA) • 45 CFR 164

PATIENT Click this button to clear all fields on this form **Patient whose information is to be released**

Social Security Number	Patient's first name	Middle name	Last name
_____–____–_____			
Use blanks at right for maiden> name, or name change, if any. >	Former first name, if any	Former middle name, if any	Former last name, if any

Daytime phone number	Street address (not Post Office Box)	City	State	Zip Code

AUTHORIZER **Person authorizing release of the information**

Check one: I am: ☐ the patient OR the patient's ☐ legal next of kin ☐ legal guardian ☐ authorized representative *(See Notes, Page 2)*

If you checked that you are the patient, leave this part blank.	Authorizer's first name	Middle name	Last name

Daytime phone number	Street address (not Post Office Box)	City	State	Zip Code

HOLDER **Person or Organization holding information, that is to release the information**

Send this authorization to the Vaughan Integrative Medicine	Person or Organization that holds the information now	Fax number, if known
	Vaughan Integrative Medicine	(336) 808-3628

Daytime phone number	Address	City	State	Zip Code
(336) 808-3627	1301-A W. Wendover Ave.	Greensboro	NC	27408

RECIPIENT **Person or Organization that is to receive the information**

Check all that apply: Holder is to transfer information to Recipient by ☐ best way ☐ mail ☐ fax ☐ email ☐ hold for pickup.

HOLDER is to release / send / deliver the information to the RECIPIENT named in this part.	Release information to: ☐ *Patient*, OR ☐ *Authorizer*, OR... ☐ Person or Organization named here	Recipient's fax number, if known

Daytime phone number	Address	City	State	Zip Code

INFORMATION **Information to be disclosed by Holder to Recipient**

I authorize the release of the following information: *(Check all that apply. Initial by hand if Sensitive information is involved.)*

☐ All health care information concerning me that you have in your possession. *(See Page 2 note concerning "Sensitive" records.)*

☐ Health care information related to the following treatment or condition: .

☐ Laboratory, Diagnostic Tests and/or X-rays

☐ Other: _____.

☐ **Sensitive information** that requires my specific consent. (*Read Notes on page 2)* My *initials* below indicate I consent to release:

Authorizer's hand written initials are required here. >

_____ Drug and/or Alcohol Abuse _____ Sexually Transmitted Disease, including HIV or AIDS

_____ Mental Health or Mental Illness, including Pain Management or Psychiatry _____ Sexual Assault

_____ Child Abuse and Neglect _____ Genetic Testing _____ Abuse of adult with a disability

This authorization covers information created ☐ at any previous time OR ☐ between (date) _____ MM/DD/YYYY and _____ MM/DD/YYYY.

This information is needed for the following purpose(s): ☐ continuing medical care, ☐ copies for personal use, and/or

☐ other purpose: _____.

This authorization will remain in effect under the following conditions: *(Check one)*

☐ No expiration date. ☐ Until the purpose is fulfilled. ☐ From the date of this Authorization until the following date: _____ MM/DD/YYYY.

☐ Until the following event occurs: .

Note: If you fail to make a choice, this Authorization will automatically expire 90 days after the date it is signed. If you are authorizing release of Mental Health records, you must fill in the "following date" above, indicating a specific term.

SIGNATURE **Signature attesting to this Authorization**

By my signature below, I agree and authorize the Holder, above, to release to the Recipient, the information described on this page. I understand that this Authorization has two (2) pages. In making this authorization, I certify that I fully understand the information on Page 1 and Page 2, including all of that section on Page 2 titled "Statement of Patient Rights," and all my questions have been answered.

Signature of patient or Authorizer named above	Date signed MM/DD/YYYY

If printed two sides on duplex printer, set to staple short side

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Statement of Patient Rights

I understand that I may change my mind and revoke this Authorization at any time by notifying the Holder. I must revoke this Authorization in writing. I understand that the revocation will not apply to information that already has been released in response to this Authorization, or if my authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.

I understand that I have the right to inspect or copy any information used or disclosed under this Authorization.

I understand that once this health information is disclosed, it may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information my no longer be protected under federal medical privacy law.

I understand that I may refuse to sign this Authorization. If I refuse, my ability to obtain treatment will not be affected unless (a) my treatment is related to research; or (b) the only purpose of treatment is to create health information for the disclosure listed in this document; or (c) an authorization is required for health plan eligibility or enrollment or a risk rating determination.

I understand that failure to sign an authorization may result in inability to obtain benefits in some cases.

I understand there may be a fee for a copy of my medical records. In North Carolina, the fee is a minimum of $10, OR 75¢ per page for the first 25 pages; 50¢ per page for pages 26 through 100; and 25¢ per page in excess of 100 pages [NC GS § 90-411].

Sensitive Information

Drug and/or Alcohol Abuse Treatment Information

A health care practitioner may not disclose the name of any person who requests treatment and rehabilitation for drug dependence to any law-enforcement officer or agency unless authorized by the person seeking treatment. The authorization must be in writing. [NC GS § 90-109.1]. Generally, federal regulations [42 CFR part 2] prohibit any further disclosure of such information except with written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, with some exceptions.

Sexually Transmitted Disease Information, including HIV or AIDS.

All information and records that identify a person who is infected with HIV, AIDS, or another reportable condition or illness are "strictly confidential" and may not be released without the identified person's written consent except as specified in the statute [NC GS § 130A-143].

Release of this information may be made without the subject's consent: a) when necessary to protect the public health pursuant to rules regarding control measures for communicable diseases; b) to health care personnel providing medical care to the patient; c) pursuant to a subpoena or court order; d) for bona fide research purposes; 3) in other specified circumstances.

Mental Health or Mental Illness, including Pain Management or Psychiatry

A client of a facility providing services for the care of the mentally ill, developmentally disabled or substance abusers have a statutory right of privacy [NC GS § 122C-51]. Upon request, facilities providing such services must give clients access to the confidential information in their client records [NC GS § 122C-3 & -53], but, the facility may deny access to information that would be injurious to the client's physical or mental well being as determined by the attending physician [NC GS § 122C53]. In this circumstance, the information is to be provided to the physician or psychologist of the client's choice. Generally, the information may not be disclosed by the facility or by an individual having access to the information without the client's consent [NC GS § 122C-52].

Psychotherapy notes

Federal law [45 CFR 164.508(b)(3)(ii)] prohibits an authorization for release of information pertaining to psychotherapy notes from being combined with an authorization for release of any other kind of records.

Genetic Test Results

North Carolina has some statutes concerning these tests. One section says employers may not deny or refuse employment, or discharge, a person based on genetic information [NC GS § 95-28.1A]. Another section says insurers can't raise premiums or refuse entry in a health plan [NC GS § 58-3-215].

If you can avoid releasing your genetic information to anyone, by all means, keep it private.

Consent of Minor

Where a minor has the right to consent to medical treatment, the minor also has the right to control information related to that treatment. Therefore, a competent minor's signature is required to release information about such treatment.

In North Carolina, a minor has the right to consent to treatment for Contraceptive services; Prenatal care; STD/HIV-AIDS services; Alcohol and/or drug treatment; and Outpatient mental health services. (American Bar Association has an excellent summary on its website at http://www.abanet.org/media/factbooks/cht1.html.)

According to the U.S. Department of Health and Human Services: "If State and other law is silent concerning parental access to the minor's protected health information, a covered entity has discretion to provide or deny a parent access to the minor's health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment."

Patient's Authorized Representative

A patient's authorized representative, or personal representative, is an individual who may act on behalf of a patient when the patient is not competent or cannot make his or her own health care treatment decisions.

In most cases (an extreme emergency would be a likely exception), the authorized representative needs legal documentation to demonstrate their authority to sign for the patient.

In general, the following classes of persons may sign for a patient who is not competent to consent, in the following order of priority: a) Appointed legal guardian of the patient; b) Individual to whom the patient has given a durable power of attorney that includes authority to make health care decisions; c) the patient's spouse; d) children of the patient who are at least eighteen years of age; e) parents of the patient, if unanimous; and f) adult brothers and sisters of the patient, if unanimous.

The U.S Department of Health and Human Services has pages of discussion about this subject at

www.hhs.gov/ocr/hipaa/guidelines/personalrepresentatives.wpd